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ORIGINAL ARTICLE

Student mental health profiles and barriers to help seeking: When and why students seek help for a mental health concern

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Abstract

Background: The student mental health landscape in higher education requires preventative strategies that maintain daily functioning as well as early intervention to respond to episodes of mental ill-health. As a community, this requires capturing the needs of students in the general university population as well as those using counselling and psychological wellbeing services.

Aims: This cross-sectional study aimed to characterise the mental health profile of students in the general university population and identify barriers to help seeking.

Methods: A total of 1,956 students from five UK universities completed an online questionnaire comprising the CCAPS-34 and open-ended questions about their mental health concerns and intentions to seek help. Mental health profiles were explored using mixed factorial ANOVAs and post hoc simple effect analyses. Help-seeking behaviours and intentions were identified using conceptual content analysis.

Results: Distinctive mental health profiles emerged across faculties and help-seeking behaviours. Content analysis identified students' help-seeking experiences, intentions, preferences and barriers.

Conclusions: Characterising the mental health profile of students outside of support services, as well as their barriers to seeking help, provides a rich understanding for shaping preventative policies and service provision. Doing so will respond to student mental health needs *before* they require clinical intervention.

KEYWORDS

help-seeking behaviour, higher education, measurement, policy, prevention, student mental health

1 | INTRODUCTION

The university community comprises a diverse population with unique needs that rapidly adapt in response to changes across higher education (HE). In the last decade, the HE sector has undergone substantial developments and new strategies reposition

student mental health as a university-wide priority in the UK and globally (Universities UK, 2020; WHO Mental Health Action Plan, 2013). The delivery of new policy frameworks is transforming the demographic profile of students, their mental health needs and their preferences for support (Stallman, 2010; Thorley, 2017). Characterising the mental health profile and help-seeking intentions

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of students outside of support services will help to identify barriers to accessing help.

2 | STUDENT MENTAL HEALTH CONTEXT AND POLICY

Student mental health is complex, and knowledge surrounding the needs of students has progressed substantially. It is recognised that the university transition marks a time of significant change that is unique to HE (Universities UK, 2015, 2020). Undergraduate students may separate from their family and friends for the first time, share housing with unknown peers and experience new cultures and languages. Students may need to undertake paid employment or adapt to managing a loan (Richardson et al., 2016). There is pressure to form relationships and establish a sense of belonging within the academic community (Cole et al., 2017). Students also differ in their readiness to seek help and marginalised students may not feel entitled to approach services (Giamos et al., 2017).

International policies have shed light on student mental health priorities. The World Health Organization (WHO) has aimed to empower individuals experiencing mental health difficulties to access support and view mental health as central to building resilience, intellectual functioning and personal growth (WHO, 2005, 2013). Cross-government policies recognise the need for early engagement and prevention alongside well-resourced interventions in confronting causes of mental ill-health and stigma (Department of Health, 2011; Universities UK, 2015, 2020). National guidelines recognise that university systems can be difficult to navigate, especially when students are distressed, and this can disproportionately create barriers for accessing support (Universities UK, 2015). UK guidance further recognises the impact that mental health, both positive and negative, can have on students' learning, community and their ability to thrive and seek support (Hughes et al., 2019; Universities UK, 2020). Early and open conversations about mental health are recognised by these frameworks and are fundamental to breaking down barriers for accessing support.

3 | CHARACTERISING NUANCES OF STUDENT MENTAL HEALTH

Half of the young adult population access HE, and student characteristics have diversified over the last two decades (see Andres et al., 1997; Johnson, 2019). Recent comparisons of student cohorts indicate that mental health complications are rising more steeply. For instance, analysis of national data identified that, compared to 2003, noteworthy changes have occurred: (1) recent cohorts (especially women) are more likely to report mental ill-health, (2) disclosures of mental health conditions have increased fivefold, and (3) 94% of UK universities report higher demands for support services and work with more complex cases (Broglia et al., 2017, 2021; Thorley, 2017). At the same time, Thorley (2017) found that almost half of students did not disclose a mental health condition

Implications for practice and policy

1. Our findings suggest that students take time to contemplate whether to seek help for their mental health and are concerned about the time commitment of receiving support. Institutions should develop proactive outreach activities with students to support earlier engagement with services.
2. Self-stigma was a prominent reason students did not seek help. Institutions should facilitate co-production activities with marginalised student groups to improve mental health literacy and combat self-stigmatising beliefs.
3. Students' mental health profiles were different across faculties, and they described stigmatising experiences from staff. Developing discipline-specific staff training would help to combat stigma surrounding mental health difficulties and ensure that staff are equipped to signpost students and encourage help seeking.
4. Students described experiences that reflect complex and long-lasting mental health issues that prevented them from seeking help and engaging with academic commitments. These findings reflect the need for in-house professional services to support students with complex and long-lasting mental health needs in a timely manner.

and the rates of student drop-out were twice as high than 10 years previous.

Differences between academic faculties have also emerged. For instance, medical students score significantly higher for depression and suicidal ideation (McKerrow et al., 2020). Staff have observed high distress among students studying law, arts and humanities (Skead & Rogers, 2015) and relatively lower distress in students studying business (Lipson et al., 2016). Other studies suggest that academic staff do not accurately perceive their students' mental health difficulties despite feeling able to recognise the signs of poor mental health (Brockelman & Scheyett, 2015; Macaskill, 2013). Similar studies suggest that, while awareness of student mental health appears high, staff inclination to intervene was low (Spear et al., 2020). These mixed findings highlight the need to characterise the demographic and mental health profile of students in the wider student population to identify areas for training.

4 | HELP-SEEKING INTENTIONS AND BARRIERS TO SUPPORT

Although more students are accessing mental health services, it is unclear whether this reflects higher incidences of poor mental health or increased awareness and engagement (Hunt & Eisenberg, 2010). Moreover, as policies prioritise mental health and increase access for students with existing diagnoses of mental illness, it is likely

that the rise reflects better reporting of a more diverse population (Brown, 2018). Notwithstanding these contributions, the demographic profile of students in receipt of counselling has remained relatively stable and is not entirely representative of the wider student community (see Thorley, 2017). Estimates of students' unmet needs vary, but figures suggest that 60%–80% of students do not approach services (Eisenberg et al., 2012; Lipson et al., 2015). Students who are male, heterosexual and conducting doctoral research appear to experience the greatest unmet need (Cullinan et al., 2019), as well as students with comorbid diagnoses of anxiety and depression (Verger et al., 2010) and social anxiety (Yuen et al., 2013).

Research has also shown that, despite holding a positive view of counselling, students prefer to approach friends, family or academic staff (Goodwin et al., 2016; Hughes et al., 2018). These trends suggest that help-seeking intentions are complex, multifaceted and that barriers to accessing mental health support affect students disproportionately (Batchelor et al., 2020). Comparisons of counselling assessments for students found that compared with the United States, UK students obtained higher clinical scores that were particularly acute for academic distress, generalised anxiety and depression (Broglia et al., 2017, 2021). This led Broglia et al. (2017) to suggest that UK students may delay approaching services until their needs are severe or impacting their studies.

There is an urgent call to action to respond to the mental health needs of students and ensure that they are best placed with appropriate support to succeed at university. Identifying the nuances of students' mental health characteristics is vital, as well as collecting robust data using bone fide measures that capture the unique context of higher education (Barkham et al., 2019). Accordingly, the current study aimed to respond to this need with the following objectives: (1) to characterise the mental health profiles of university students in the general student population; (2) to identify differences between universities, faculties and help-seeking intentions; and (3) to garner a rich understanding of students' mental health concerns and barriers to accessing support.

5 | METHOD

5.1 | Design and setting

The present study used a cross-sectional online questionnaire, including quantitative and qualitative questions, across five UK universities in March 2016. Universities were from different geographical regions representing small to large cities, towns and rural campuses and with the total number of registered students ranging from 10,000 to 25,000.

5.2 | Profiling student mental health with the CCAPS-34

The 34-item version of the Counseling Center Assessment of Psychological Symptoms (CCAPS-34) is a student-specific measure,

and it was used to characterise psychological experiences specific to the student population (Locke et al., 2012). Permissions were sought from the measure developers to include the CCAPS-34 in the online survey, and no changes were made to the measure. The CCAPS-34 is a shorter version of the CCAPS-62 and both are typically used in university counselling services to assess student-specific psychological experiences. Items refer to the previous two weeks and the CCAPS-34 measures depression, generalised anxiety, social anxiety, academic distress, eating concerns, hostility, alcohol use and overall distress. Items are rated on a 5-point Likert scale (0 = not at all like me, 4 = extremely like me) with higher scores indicating higher severity. The CCAPS is a psychometrically robust measure that correlates with domain-specific measures (e.g. alcohol use, depression and anxiety; see Locke et al., 2012). UK data from the CCAPS have also been published, including an initial validation against other UK measures (see Broglia et al., 2017, 2021).

5.3 | Survey questions and procedure

The CCAPS-34 was created as an online questionnaire (<https://qualtrics.com/>) alongside questions that captured (1) demographics (e.g. age, gender), (2) institution (e.g. degree faculty), (3) mental health concerns and diagnoses (e.g. anxiety), and (4) help-seeking behaviours (e.g. previously sought help). Students' help-seeking status was identified using the following questions: (1) "Have you *previously* received support from your institution's counselling and/or psychological wellbeing service?" (2) "Are you *currently* receiving support from your institution's counselling and/or psychological wellbeing service?" And (3) "have you had concerns about your mental health and decided not to seek help from your institution's counselling and/or psychological wellbeing service?" These questions were accompanied by open text options to allow participants to name the services they had used and their reasoning. The answers were multiple choice except for questions requiring elaboration of students' concerns and reasons for seeking or avoiding help. An anonymous weblink to the questionnaire was emailed to student volunteer lists and remained open for seven days. Ethical approval was received from the University of Sheffield Research Ethics Committee (Ref: 1,144), and participants provided consent for their data to be used in this research.

5.4 | Participants

Participants were 1,956 students registered at one of five UK universities with a mean age of 24 years ($SD = 7.07$; min = 18, max = 69). Table 1 shows that 15%–27% of students were registered at each university. Students were predominantly studying in their home/birth country, were undergraduate and were female. The largest faculty represented was science, and the smallest faculty was engineering.

TABLE 1 Breakdown of students who completed the survey across university, faculty and demographic categories

	Count (<i>n</i> = 1,956)	%
University		
Sample 1	349	18
Sample 2	397	20
Sample 3	431	22
Sample 4	522	27
Sample 5	245	13
Missing	12	1
Fee status		
Home/birth country	1,271	65
International	55	3
Other (e.g. exchange)	630	32
Missing	-	-
Study level		
Undergraduate	1,539	79
Postgraduate (taught)	157	8
Postgraduate (research)	257	13
Missing	3	0.1
Faculty		
Arts and humanities	495	25
Engineering	107	6
Medicine/dentistry/nursing	231	12
Science	654	33
Social Science	458	23
Other	5	0.3
Missing	6	0.3
Gender		
Female	1,398	71
Male	506	26
Custom	16	1
Rather not specify	25	1
Missing	11	1
Help-seeking behaviour*		
Previously received support (Y)	630	32
Previously received support (N)	1,271	65
Received support during data collection (Y)	206	11
Received support during data collection (N)	1,711	87
Avoided seeking help during time at university (Y)	763	39
Avoided seeking help during time at university (N)	1,073	55
Missing	20	1

*Data have not been displayed for students who answered 'unsure'.

5.5 | Analytic strategy

Quantitative analysis was performed in SPSS statistics package (version 21), and qualitative analysis was performed in NVivo (version 11). Students' mental health profiles were characterised using descriptive statistics on CCAPS-34 domain scores to identify patterns of symptom severity. Mixed factorial ANOVAs with Bonferroni-corrected simple effect analyses were used to explore differences in symptom profiles between universities, faculties and help-seeking behaviours. Conceptual content analysis was used on the open-text comments from the survey to identify students' mental health concerns and barriers to accessing support (Krippendorff, 1980). This process involved inductively coding data and assigning codes, clustering codes into themes and sub-themes and reviewing themes alongside coded extracts in the original dataset. This procedure was led by author EB and reviewed by author MB.

6 | RESULTS

6.1 | Survey completion

On average, students took 5 minutes and 19 seconds to complete the survey, and this was shorter for participants who did not provide comments (min = 00:02:30, max = 00:54:00, *SD* = 00:05:10). Table 1 shows that most students had not previously received support for a mental health concern and were not receiving mental health support during the time of data collection.

6.2 | Missing items

The overall rate of missing items on the CCAPS-34 was 0.0049% (471 missing items/95,676 data points distributed across all items ranging between 6 and 16 missing items per question). The highest rate of missing items was found on two items relating to eating concerns ("I eat too much" and "I think about food more than I should"), generalised anxiety ("My thoughts are racing") and hostility ("I have thoughts of hurting others").

6.3 | Percentage of students scoring maximum and minimum scores

Ceiling effects were explored by calculating the percentage of students that obtained a maximum score (4 = extremely like me) on any scale. The highest percentage of maximum scores was for eating concerns (*n* = 149, 5%), followed by depression (*n* = 52, 2%), alcohol use (*n* = 42, 2%), generalised anxiety (*n* = 32, 1%), hostility (*n* = 7, 0.3%) and academic distress (*n* = 4, 0.14%). There were no maximum scores for social anxiety or distress. Floor effects were explored by calculating the percentage of students that obtained a minimum score (0 = not at all like me) on any scale. Minimum scores were met on all subscales

in the following descending order: alcohol use ($n = 924$, 33%), eating concerns ($n = 580$, 21%), hostility ($n = 524$, 19%), depression ($n = 195$, 7%), generalised anxiety ($n = 65$, 2%), distress ($n = 6$, 0.22%), social anxiety ($n = 4$, 0.14%) and academic distress ($n = 1$, 0.04%).

7 | STUDENT MENTAL HEALTH PROFILES

According to the subscale means on the CCAPS-34, students obtained the highest score on social anxiety (mean = 2.18, $SD = 0.74$), followed by academic distress (mean = 1.97, $SD = 0.77$), generalised anxiety (mean = 1.83, $SD = 1.01$), distress (mean = 1.71, $SD = 0.88$), depression (mean = 1.65, $SD = 1.09$), eating concerns (mean = 1.54, $SD = 1.26$), alcohol use (mean = 0.98, $SD = 1.10$) and hostility (mean = 0.85, $SD = 0.80$). Figure 1 illustrates two clusters on the CCAPS-34 with higher social anxiety and academic distress with lower hostility and alcohol use.

A 5×8 mixed factorial ANOVA was used to explore differences across universities and symptoms. The main effect of symptom was significant ($F(7, 1,495.87) = 637.98$, $p < .001$, $\eta^2 = 0.65$), whereas the main effect of university and the interaction were not significant (university effect: $F(4, 1,388) = 1.80$, $p = .126$, $\eta^2 = 0.0$; interaction: $F(28, 9,716) = 1.31$, $p = .127$, $\eta^2 = 0.11$). Across the universities, students scored highest on social anxiety, followed by academic distress, generalised anxiety, distress, depression and least for hostility (see supplementary materials). With both the main effect of university and the interaction not significant, universities were combined to permit comparisons at the faculty level. A 5×8 mixed factorial ANOVA was used to explore differences across faculties and symptoms. The main effects of symptom and faculty were significant, as well as the interaction (symptom: $F(7, 506.51) = 177.88$, $p < .001$, $\eta^2 = 0.60$; faculty: $F(4, 468) = 7.09$, $p < .001$, $\eta^2 = 0.06$; interaction: $F(28, 1,751.28) = 1.86$, $p = .004$, $\eta^2 = 0.02$).

Table 2 shows that, across the faculties, students from social sciences scored highest on 6 out of the 8 CCAPS-34 subscales (75%),

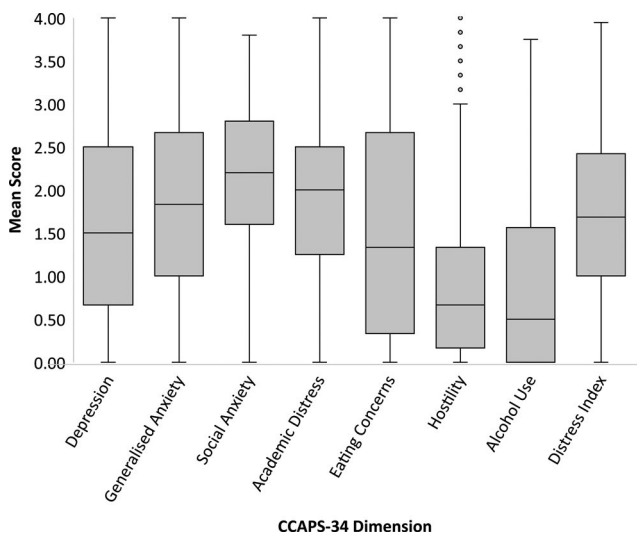


FIGURE 1 Mental health profile of students outside the counselling service on the CCAPS-34 ($n = 1,841$)

TABLE 2 Means together with their ranks and SDs of scores on the CCAPS-34 subscales for students' faculties combined across five universities

	Arts ($n = 475$)		Engineering ($n = 103$)		Medicine ($n = 215$)		Science ($n = 613$)		Social Science ($n = 441$)		Total sample ($n = 1,847^a$)	
	Mean (rank)	SD	Mean (rank)	SD	Mean (rank)	SD	Mean (rank)	SD	Mean (rank)	SD	Mean (rank)	SD
Depression	1.69 (5) [†]	1.18	1.40 (5)	1.01	1.49 (6)	1.09	1.68 (5)	1.08	1.69 (5) [†]	1.10	1.50 (6)	0.04
GAD	1.90 (3) [*]	1.02	1.56 (3) [*]	0.98	1.70 (3)	1.03	1.82 (3)	0.98	1.91 (3) ^{†*}	1.01	1.72 (3)	0.04
Social anxiety	2.21 (1) ^{†*}	0.76	2.03 (1)	0.69	2.02 (1) [*]	0.73	2.21 (1) [†]	0.71	2.21 (1) ^{†*}	0.75	2.10 (1) [†]	0.03
Academic distress	2.00 (2)	0.78	1.90 (2)	0.71	1.89 (2)	0.77	1.98 (2)	0.76	2.01 (2) [†]	0.80	1.92 (2)	0.03
Eating concerns	1.51 (6)	1.30	1.29 (6)	1.17	1.63 (4) [†]	1.26	1.57 (6)	1.26	1.57 (6)	1.25	1.54 (5)	0.06
Hostility	0.85 (8)	0.80	0.80 (8)	0.79	0.80 (8)	0.85	0.87 (8) [†]	0.80	0.85 (8)	0.80	0.86 (8)	0.03
Alcohol use	0.94 (7)	1.05	0.93 (7)	1.01	0.87 (7)	1.02	0.99 (7)	1.09	1.07 (7) [†]	1.13	0.93 (7)	0.05
Distress index	1.75 (4) [†]	0.87	1.49 (4)	0.83	1.57 (5)	0.89	1.72 (4)	0.85	1.75 (4) [†]	0.86	1.60 (4)	0.03
Sample Mean	1.59	-	1.43	-	1.42	-	1.41	-	1.77	-	-	-
SD	0.08	-	0.05	-	0.07	-	0.08	-	0.06	-	-	-

^aMissing = 109.

[†]Represents the highest mean across the faculties.

^{*}Significant Bonferroni-corrected post hoc simple effect analyses ($p < .001$).

followed by students from arts (3/8, 38%), science (2/8, 25%), medicine (1/8, 13%) and engineering (0/8). Table 2 also shows specific symptom clusters for students from certain faculties including: (1) arts students scored the highest on social anxiety, distress and depression; (2) science students scored the highest on social anxiety and hostility; (3) medical students scored the highest for eating concerns; and (4) engineering students scored the lowest overall.

The final comparison involved allocating students into three groups: (1) reported avoiding help for a mental health concern, (2) previously received support, and (3) were receiving support during data collection. A 3×8 mixed factorial ANOVA was used to explore differences across help seeking and symptoms. The main effects of help seeking and symptom were significant, as well as the interaction (help seeking: $F(2, 400) = 6.05, p = .003, \eta^2 = 0.03$; symptom: $F(7, 1,400) = 255.13, p < .001, \eta^2 = 0.56$; interaction: $F(14, 2,800) = 2.02, p = .013, \eta^2 = 0.01$). Table 3 shows that students who received support during data collection scored the highest overall, followed by students who previously received help. Table 3 also shows that students who received support scored the highest on 5 out of 8 CCAPS-34 subscales including depression, generalised anxiety, social anxiety, academic distress and overall distress. Students who avoided help scored the highest on alcohol use compared with other students.

7.1 | Student mental health concerns and help-seeking intentions

Of the 1,956 students that completed the survey, 1,011 (52%) provided comments to the question 'Have you considered

seeking help from your university counselling and/or psychological wellbeing service since your time at university?' Table 4 shows two overarching themes that emerged from content analysis: (1) students' reasons for considering help, including having concerns for their mental health and describing severe or complex issues, and (2) intentions for and barriers to help seeking, including distinct help-seeking behaviours, barriers to services, preferences for support and stigma. Distinct help-seeking behaviours were explored further, and Figure 2 presents phases of help seeking including: (1) early contemplation, (2) deciding that help is needed and exploring options, and (3) deciding that help is needed and seeking help. The themes from students' comments have been described below.

7.1.1 | Students' areas of concern for their mental health

Students reported 28 different mental health concerns that included areas specific to HE (e.g. examination stress and adjustment issues) and broader mental health issues (e.g. relationship problems). Most students described anxiety, depression and academic distress with fewer students describing sleep problems, self-harm or housing issues. Few students disclosed being a victim of crime or fearing terrorism.

I struggle with anxiety especially near deadlines. I get so stressed I can't think... I go a day without eating because of my nerves... I have so much on my mind I forget to eat [until] I've bitten my nails down to the skin.

TABLE 3 Means together with their ranks and SDs of scores on the CCAPS-34 subscales for students who self-identified as avoiding help for a mental health concern, previously received help and were receiving help during data collection

	Avoided help (<i>n</i> = 739)		Previous help (<i>n</i> = 588)		Current help (<i>n</i> = 189)		Total sample (<i>n</i> = 1,516)	
	Mean (rank)	SD	Mean (rank)	SD	Mean (rank)	SD	Mean (rank)	SD
Depression	2.04 (4)	1.05	2.05 (4)	1.09	2.22 (4) ^{†,*}	0.99	1.99 (5)	0.04
GAD	2.15 (3)	0.96	2.19 (2)	0.99	2.37 (2) ^{†,*}	0.93	2.16 (2)	0.05
Social anxiety	2.33 (1)	0.71	2.36 (1)	0.70	2.45 (1) ^{†,*}	0.69	2.30 (1)	0.06
Academic distress	2.18 (2)	0.72	2.17 (3)	0.76	2.32 (3) ^{†,*}	0.73	2.16 (2)	0.04
Eating concerns	1.66 (6)	1.29	1.68 (6) [†]	1.29	1.67 (6)	1.33	1.56 (6)	0.05
Hostility	1.00 (8)	0.87	0.97 (8)	0.80	1.03 (7) [†]	0.82	1.01 (7)	0.04
Alcohol use	1.13 (7) ^{†,*}	1.19	1.00 (7)	1.10	1.02 (8)	1.09	0.98 (8)	0.05
Distress index	2.03 (5)	0.80	2.05 (4)	0.83	2.20 (5) ^{†,*}	0.74	2.01 (4)	0.03
Sample mean	1.75	-	1.69	-	1.88 [†]	-	-	-
SD	0.03	-	0.04	-	0.06	-	-	-

^aDoes not include students that answered no or unsure (avoided = 1,106, missing = 850; previous = 1,269, missing = 687; current = 1,661, missing = 295).

[†]Represents the highest score across the help-seeking groups.

*Significant Bonferroni-corrected post hoc simple effect analyses ($p < .001$).

7.1.2 | Severity and complexity of concerns

Concerns were complex, severe and, on occasion, long-lasting. Being prescribed medication or being referred to a long-term psychological service were commonly mentioned.

I struggle with anxiety and OCD which makes me feel lonely and like I'm not worthy of a degree... I fall behind on work as I can't bring myself to get up in the morning or go to seminars... I'm too scared to walk in the doors.

I know I need to go back to counselling, but I worry that they won't/can't help me anymore than what CAMHS¹ did two years ago.

I was commuting every day and suffering from anxiety, mostly associated with deadlines and workload. The thought of committing time to counselling increased my anxiety.

I considered getting help for anxiety but chose not to as the process of getting help made me feel more anxious.

7.1.3 | Help-seeking intentions and behaviours

Distinct help-seeking behaviours emerged as three concrete phases, with the first being early contemplation which included feeling too uncertain or unwell to explore options (Figure 2, phase 1). These behaviours included 'putting it off' until their needs worsened or because they were concerned about their lack of time.

TABLE 4 Summary of overarching themes and sub-themes that emerged from students' comments when considering seeking help for a mental health concern from their university counselling service

Students' reasons for considering mental health support from their university	Intentions for help-seeking and barriers to accessing support from the university
1. Students' areas of concern for their mental health	1. Help-seeking intentions and behaviours
	2. Barriers to accessing counselling
2. Severity and complexity of concerns	3. Preferences for, and access to, alternative support
	4. Stigma

7.1.4 | Barriers to accessing the university counselling service

Following early contemplation, students either decided that help was not needed, or they explored their options (Figure 2, phase 2). Here, students described structural barriers to accessing services (e.g. not knowing the support available) or being 'put-off' by the information provided to them and their knowledge of services. Students described counselling services as 'being thinly stretched' or disagreeing with their referral, which could prohibit further help seeking.

I did [explore counselling] but it was close to Christmas and thought I wouldn't get an appointment before the break.

They wanted to refer me for more complex mental health difficulties... I just wanted help with immediate exam stress, so I decided not to go ahead with any support.

7.1.5 | Preferences for, and access to, alternative mental health support

Once students explored their options, a proportion of students described receiving help either from the counselling service or alternative mental health support (Figure 2, phase 3). Alternative support

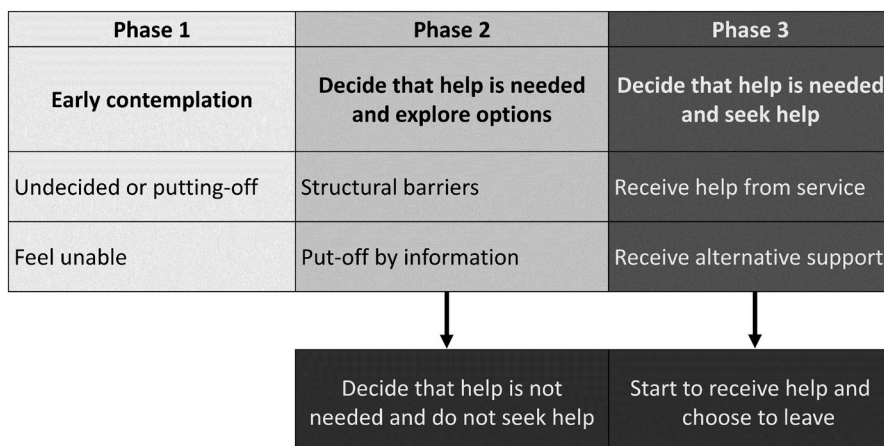


FIGURE 2 Summary of themes characterising different types of help-seeking behaviour at different phases throughout the process of students considering help for a mental health concern

included online self-help, mental health advisors, the health service and talking to friends or family. A small group of students described dropping-out of counselling if they felt it was no longer needed or wanted to handle their problems alone.

deciding to see someone made the problem more real and I thought I can cope with the stress on my own. Plus, I have a great network of friends that have helped me enormously.

7.1.6 | Experiences of stigma and self-stigma

Students referenced stigma throughout the overarching themes, which impacted their help-seeking intentions and created barriers to accessing support. Some students described stigmatising experiences, whereas others provided examples of self-stigma such as holding the belief that mental health problems are necessary to 'survive' university and prepare them for life beyond their degree.

I think everyone goes through roughly the same amount of stress so why should I be the weak one and seek help when other people have not needed support and survived university?

After trying many times to get support from the health service, the anxiety and dyslexia service and my personal tutor and being told to just deal with it, I stopped looking.

8 | DISCUSSION

The current study used a cross-sectional questionnaire using both quantitative and qualitative questions to gather broad and rich data on students' mental health and help-seeking intentions. As a sample, students demonstrated higher social anxiety, generalised anxiety and academic distress compared with other issues. Students' self-identified help-seeking behaviours and intentions revealed a three-phase process beginning with early contemplation, moving to exploring support options and, for some, ending with their preferred support. Barriers to accessing mental health support were complex, multifaceted and often reflected challenges recognised in recent policy recommendations.

8.1 | Mental health profiles of university students

There is an abundance of student surveys reporting inconsistent or confounding mental health issues and few that have used valid measures designed for this population (Barkham et al., 2019; Cage et al., 2020). The current study employed a measure designed to

assess mental health difficulties of university students (CCAPS; see Locke et al., 2012) and identified pronounced levels of social anxiety, generalised anxiety and academic distress. This pattern broadly mirrors other studies using the CCAPS. Students in the current study were characterised more by anxiety over other experiences. For example, Broglia et al. (2017, 2021) identified high academic distress, social anxiety, generalised anxiety and depression in UK students who approached counselling services. The pattern of anxiety displayed in the current sample illustrates the need to develop institutional strategies that offer proactive outreach activities and preventative interventions that facilitate early engagement.

8.2 | Differences across academic faculties

Engineering students in the current study met lower clinical criteria on all measures, and this was most noticeable for anxiety. Medical students also scored lowest on academic distress, whereas social science students scored the highest on 75% of mental health symptoms. Similar differences have emerged in other studies. For instance, a study of 64,000 students across 81 institutions found that arts and humanities students were more likely to experience mental health problems including anxiety, depression and suicidal ideation (Lipson et al., 2016). They also found that both nursing and engineering students were less likely to report suicidal ideation and engineering students were the least likely to seek help. Together, these findings suggest that students would benefit from having access to support embedded into faculties and catered to their discrete needs. This approach responds to recommendations to adopt a whole university approach to mental health (Universities UK, 2020). However, the evidence supporting preventative measures is mixed and requires more investigation (see Conley et al., 2017; Slavin, 2016).

8.3 | Students' mental health concerns

Analysis of students' mental health concerns in the current study both replicates international reports and provides rich insight into students' lived experiences. Anxiety, depression and academic distress were the most prominent experiences described by students. Studies using clinical measures have estimated a 15% prevalence of an anxiety or depression disorder in undergraduates (Eisenberg et al., 2007), with 14%–17% reaching moderate-to-severe levels (Hoying et al., 2020). Aside from symptomology, students in the current study described mental health difficulties that prevented them from attending lectures, engaging with social activities, and caused them to question their belonging at university. A proportion of students described reduced functioning or mental health problems that required medication and long-term specialist services. These accounts replicate the wider literature, which suggests that students' mental health needs are complex and increasingly more severe (e.g. Hoying et al., 2020).

8.4 | Barriers to accessing support

Students in the current study described barriers that broadly concerned having inaccurate or limited knowledge of support options and reduced literacy for knowing what constitutes a mental health issue and when to seek help. Students also described stigmatising experiences as well as self-stigma, with specific concerns surrounding disclosure and uncertain consequences on academic commitments. These experiences echo recent literature concerning students' mental health literacy, which in turn contribute to the surrounding stigma (Cage et al., 2020; Hartrey et al., 2017). Regarding physical barriers, students in the present study described limited availability to approach services and found the process difficult. These findings mimic service barriers described in policy frameworks (e.g. Universities UK, 2020) that could be addressed with co-production activities to simplify advice (see Sagar-Ouriaghli et al., 2020; Tapsell et al., 2020).

There are noteworthy limitations to the present study as findings overrepresented students who were female, undergraduate, heterosexual and White. There is a need for more detailed and representative exploration of barriers to accessing mental health support that concretely identify strategies to break down barriers for discrete student groups. Data on students' socioeconomic status are also needed to help explore its impact on help seeking, as there are known inequalities within this student group and the link between mental health and socioeconomic status is well known (Basi et al., 2019; Weitzman, 2004). The present study mirrors the literature and aligns with current policy recommendations including encouraging early conversations to destigmatise mental health difficulties, building interdisciplinary partnerships to simplify access and investing in mental health services alongside diverse prevention strategies.

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ENDNOTE

¹ Child and Adolescent Mental Health Services in the UK.

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